EXHIBIT 27

EXPERT REPORT OF JOHANNA OLSON, M.D.

1. I, Johanna Olson, M.D., author this independent expert report based on my personal knowledge, except where otherwise indicated.

2. I have been asked to provide an expert opinion on the exclusions of Medicaid coverage for individuals with gender dysphoria who are under 18 and 21 years of age, as provided in 18 N.Y.C.R.R. § 505.2(*l*). Specifically, the regulation provides that hormone therapy is not available for individuals under eighteen years of age (§ 505.2(*l*)(2)) and gender reassignment surgery only may be available to individuals eighteen years or older, or twenty-one years and older if the surgery results in sterilization.

3. In authoring this report, I have reviewed the following materials: (1) Amended Class Action Complaint in this action, dated March 27, 2015; (2) Proposed Rule Making of Regulation 18 N.Y.C.R.R. § 505.2(*l*), published in New York State Register on December 17, 2014 ("§ 505.2(*l*)"; (3) Notice of Adoption of 18 N.Y.C.R.R. § 505.2(*l*), as amended, published in the New York State Register on March 11, 2015; (4) Policy and Billing Guidance for Regulation 18 N.Y.C.R.R. § 505.2(*l*), published in the March 2015 Department of Health Medicaid Update Newsletter ("Guidance"). I understand that discovery in this matter is ongoing and that, as a result, testimony from witnesses has yet to be taken and additional documents may be produced. I reserve the right to amend, supplement and/or modify my Report upon review of those materials.

QUALIFICATIONS AS AN EXPERT

4. I received my Doctor of Medicine (M.D.) degree from the Chicago Medical School in 1997. In 2000, I completed my residency in pediatrics at the Children's Hospital of Orange County, California, and from 2000 to 2003, I was a Fellow in adolescent medicine at the Children's Hospital of Los Angeles.

5. I have been a licensed physician in California since 2000 and am Double Board Certified by the American Board of Pediatrics and in Adolescent Medicine. I specialize in the care of transgender youth and gender variant children, and am currently the Medical Director at the Center for Transyouth Health and Development, in the Division of Adolescent Medicine at the Children's Hospital in Los Angeles, California. The Center is the largest clinic in the United States for transgender youth and provides gender non-conforming youth with both medical and mental health services, including consultation for families with gender non-conforming children and routine use of medications to suppress puberty in peri-pubertal youth. Under my direction, the Center conducts rigorous research programs aimed at understanding the experience of gender non-conformity from childhood through early adulthood.

6. I have been awarded research grants to examine the impact of a multidisciplinary care team approach to treating transgender youth and on the impact of hormone blockers on the physiological and psychosocial development of gender non-conforming peri-pubertal youth. I have lectured extensively on the treatment and care of gender non-conforming children and transgender adolescents, the subjects including pubertal suppression, cross-sex hormone therapy, transitioning teens and the adolescent experience, age considerations in administering cross-sex hormones, and the needs, risks, and outcomes of hormonal treatments. I have published

numerous articles and chapters, both peer reviewed, and non-peer reviewed, on transgender health-related issues.

7. I am also an Assistant Professor at Children's Hospital of Los Angeles. I have been a member of the World Professional Association for Transgender Health (WPATH) since 2010 and of the Society for Adolescent Health and Medicine since 2006. In addition, I serve on the Executive Board of Transyouth Family Allies and am a member of the LGBT Special Interest Group of the Society for Adolescent Health and Development. I am the 2014 Recognition Awardee for the Southern California Regional Chapter of the Society for Adolescent Health and Medicine. A copy of my CV is attached as Exhibit 1.

8. In the previous four years, I have testified as an expert by deposition or at trial in Jaqueline Miller vs. Travis Perdue, Case No. 10 DR 581 (Colorado) and Paul Elio vs. Courtney Flanagan. FC2010-051045 (Arizona).

9. My consulting fee on this is $50 per hour, regardless of outcome.

10. I have had no business relationship with any of the named plaintiffs other than to serve as an expert in this matter. I do not know any of them personally, and I have no expectation of further compensation from them or business with them in the future. I have had no business relationship with Plaintiffs' counsel other than to serve as an expert in this matter. I do not know them personally, and I have no expectation of further compensation from them or business with them.

GENDER DYSPHORIA AND ITS TREATMENTS

11. Gender Dysphoria (GD) is a serious medical condition characterized by an extreme sense of distress due to a mismatch between assigned birth sex and a person's internal sense of their gender. GD was formerly known as Gender Identity Disorder (GID) but the condition was renamed in May 2013, with the release by the American Psychiatric Association (APA)'s fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-V). In announcing this change, the APA explained that in addition to the name change, the criteria for the diagnosis was revised "to better characterize the experiences of affected children, adolescents, and adults." The APA further stressed that "gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition."

12. For a person to be diagnosed with GD, there must be a marked difference between the individual's expressed/experienced gender and the gender others would assign to the individual, and it must continue for at least six months. In children, the desire to be of the other gender must be present and verbalized.[1] The condition must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The APA statement further noted that treatment options for this condition include counseling, hormone therapy, gender reassignment surgery, and social and legal transition to the desired gender.

13. Cross-gender identification often emerges in childhood, with a more developed psychological sense of gender identity emerging in adolescence. While many children who exhibit cross-gender behavior in childhood do not go on to have transgender identities in

[1] Notably, the DSM-IV included a separate diagnosis for GID in children, which required the child to display a number of behaviors stereotypical of the non-natal gender. That diagnosis, and its list of behavioral requirements, have been deleted from the DSM-V.

adolescence, gender dysphoria will not remit for most youth who cross-gender identify as adolescents and adults.

14. Youth with GD are at high risk for depression, anxiety, isolation, self-harm and suicidality at the onset of puberty-related changes that feel wrong to them. With the increased media attention being directed toward the subject of gender non-conformity, young adults are "coming out" as transgender at an earlier age, and those experiencing GD are seeking medical care at, or sometimes even before, the onset of puberty.

15. The most effective treatment for adolescents and young adults with GD, in terms of both their mental and medical health, contemplates an individualized approach. Medical and surgical treatment interventions are determined by the care team (usually a medical and mental health professional) in collaboration with the patient, and the patient's family. These medical decisions are made by the care team in conjunction with the patient and the patient's family that consider the patient's social situation, the level of gender dysphoria, and other relevant factors. Often, treatment begins with pubertal suspension (also referred to as puberty blockers), later followed by cross-sex hormones. Gender-affirming genital surgeries are generally sought after cross-sex hormone treatment, but male chest reconstruction, breast augmentation, and facial feminization may be pursued earlier in an individual's transition process.

16. *Puberty blockers*: The beginning signs of puberty in transgender youth (the development of breast buds in assigned females and increased testicular volume in assigned males) is often a painful and sometimes traumatic experience that brings increased body dysphoria and the potential development of a host of comorbidities including depression, anxiety, substance abuse, self-harming behaviors, social isolation, high-risk sexual behaviors,

and increased suicidality. Puberty blocking, which involves the administration of gonadotrophin-releasing hormone analogues (GnRH), essentially suppresses puberty, thereby allowing the young person the opportunity to explore gender without having to experience the anxiety and distress associated with developing the undesired secondary sexual characteristics. In addition, for parents/guardians uneducated about gender nonconformity and/or who have only recently become aware of their child's transgender identity, puberty blockers provide additional time and opportunity to integrate this new information into their own experience and to develop skills to support their child's transition. Puberty suppression also has the benefit of potentially rendering obsolete some gender-confirmation surgeries down the line, such as male chest reconstruction, tracheal shave, facial feminization, and vocal cord alteration, which otherwise would be required to correct the initial "incorrect" puberty.

17. Puberty suppression has been used safely for decades in children with other medical conditions, and it is a reversible intervention. If the medication is discontinued, the young person continues their puberty -- either as their assigned natal sex if they decide not to transition or as their identified sex if they commence cross-sex hormone therapy -- where they had left off at the time they commenced the puberty-blocking therapy. The "Dutch protocol," developed from a study conducted in the Netherlands and published in 2006, calls for the commencement of puberty blockers for appropriately diagnosed and assessed gender dysphoric youth as early as 12 years of age. Both the Endocrine Society and the WPATH's Standards of Care, however, recommend initiation of puberty suppression at the earliest stages of puberty, regardless of chronological age, in order to avoid the stress and trauma associated with developing secondary sex characteristics of the natal sex.

18. The available data on the psychological impact of puberty suppression treatment in gender-nonconforming youth show a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning.

19. Puberty blockers, thus, afford youth the opportunity to undergo a single, correct pubertal process and avoid many of the surgical interventions previously necessary for assimilation into an authentic gender role. It is a simple reversible intervention that has the capacity to improve health outcomes and save lives. Over the course of my work in the past eight years with gender non-conforming and transgender youth, I have prescribed hormone suppression for over 50 patients. Every one of those patients has benefitted from putting their endogenous puberty process on pause. Many of these young people were able to matriculate back into school environments, begin appropriate peer relationships, participate meaningfully in therapy, and family functions. Children who had contemplated or attempted suicide or self-harm (including cutting and burning) associated with monthly menstruation or the anxiety about their voice dropping were offered respite from those dark places of despair. GnRH analogues for puberty suppression are, in my opinion, a sentinel event in the history of transgender medicine, and have changed the landscape almost as much as the development of synthetic hormones.

20. *Cross-gender hormones*: Cross-gender or cross-sex hormone therapy involves administering steroids of the experienced sex (estrogen for transgender females and testosterone for transgender males), in order to attain the appropriate masculinization or feminization of the transgender person to achieve a gender phenotype that matches as closely as possible to the self-identified gender. Cross-sex hormone therapy is a partially reversible treatment in that some of the effects produced by the hormones are reversible (e.g., changes in body fat composition, decrease in facial and body hair) while others are irreversible (e.g., deepening of the voice,

decreased testicular mass). The Endocrine Society guidelines recommend providing cross-sex hormone treatment starting at age sixteen but do not require it. Eligibility and medical necessity should be determined case-by-case, based on an assessment of the youth's unique cognitive and emotional maturation and ability to provide a knowing and informed consent. The decision would be made only after a careful review with the youth and parents/guardians of the potential risks and benefits of cross-sex hormone therapy. The youth's primary care provider, therapist, or another experienced mental health professional can help document and confirm the patient's history of gender dysphoria, the medical necessity of the intervention, and the youth's readiness to transition medically. It is important to recognize that if puberty suppression is indeed happening at the time in which it yields the most benefit (before the development of undesired secondary sex characteristics) it will happen chronologically between the ages of 9 and 12 years. Even waiting until 16 would necessitate a youth being on blocking medication for up to 7 years. The process of puberty suppression results in a slowing down of bone density acquisition, resulting in a longer delay before peak bone mineral density is obtained. Additionally, there are psychosocial consequences of going through a process (puberty) in late adolescence that should have been happening at 9 or 10 years of age. In youth experiencing constitutional delay of puberty, there have been proven negative social consequences of going through puberty in late adolescence compared to peers. The requirement that transgender youth wait until 18 to commence puberty is not only immensely problematic, it is also discriminatory. For the purpose of example, any child who begins puberty too early, at the age of 4 or 5 years, receives GnRH analogues to halt that premature process. At the age of 12, GnRH analogues are discontinued, and that child is "allowed" to progress through puberty. This indicates that as a medical community, we believe children should start puberty at around 12 years of age. This same

principle is not applied to transgender youth, who are required to wait until 18 in New York. If these recommendations are rooted in the belief that gender identity is not solidified until late adolescence, that belief is incorrect. What is actually known about gender identity is that it is solidified in early childhood (Slaby R, Frey K. Development of Gender Constancy and Selective Attention to Same Sex Models, *Child Development*, Vol. 46, No. 4, pp. 849-856, 1975.)

21. *Gender-affirming surgeries*: The last steps in the gender reassignment process may involve surgical interventions that create irreversible changes to the body to match the experienced gender. These include vaginoplasty, tracheal shave, liposuction, breast implants, and orchiectomy for transgender females and male chest reconstruction, hysterectomy, oophorectomy, salpingectomy, construction of neoscrotum, and metoidioplasty or phalloplasty for transgender males.

22. The New York State regulation provides that gender reassignment surgeries may be covered for individuals 18 years of age or older, or 21 years of older if the procedure will result in sterilization. These age limits lack an adequate scientific or factual basis. The WPATH Standards of Care recommend that genital surgery – i.e., surgery which will render the individual sterile – not be carried out until the individual reaches the legal age of majority to give consent for medical procedures in a given country. In the United States, that age is 18. The 21-year-old age limit in the regulation is thus inconsistent with the WPATH Standards. In addition, the Standards recommend that the other surgical interventions (e.g., chest surgery for transgender males and breast augmentation for transgender females) can occur earlier than genital surgery, preferably after ample time living in the desired gender role and after one year of cross-sex hormone therapy. The Standards of Care, however, further recognize that these are individual

determinations and that "different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression."

23. Transgender youth who were not afforded the opportunity to have puberty suppression prior to the development of secondary sex characteristics experience tremendous anguish around those parts of their bodies. For example, the development of breasts is a source of intense distress for transgender boys and is a constant reminder of an undesired developed body. The presence of breasts is the single most common clue to gender-categorize someone as female. Most transgender males choose to hide their breasts by binding them with ace bandages, tight commercial binders, or sometimes even duct tape. Binding is painful, hot and time consuming. It can lead to chronic back pain. It also creates a barrier to regular exercise for many. Transgender boys with breasts cannot participate in many activities with their peers that necessitate removing their shirts. Male chest reconstruction is an absolute necessity for young transgender males to alleviate their physical discomfort, depression, anxiety and dysphoria that comes with a body that does not correlate to their internal gender identity.

24. Transgender girls are challenged with navigating high school with male genitals. This is difficult and painful enough, but particularly at a developmental time when emerging sexuality is at a premium. There are many young girls in my practice who put their lives on hold waiting for surgical interventions. It cannot be stressed enough that surviving adolescence with the wrong body parts is mentally and emotionally damaging for transgender youth.

25. Medical necessity for transition related medical care is outlined comprehensively in the WPATH Standards of Care. I am including below a list of resolutions passed by several major professional societies regarding the medical necessity of gender related mental health, medical and surgical care for transgender identified individuals.

Medical Necessity Statements for Gender Reassignment Care

American Medical Association

Resolution: Removing Financial Barriers to Care for Transgender Patients

"An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment for many people diagnosed with GID … Therefore, be it RESOLVED, that the AMA supports public and private health insurance coverage for treatment of gender identity disorder." http://www.ama-assn.org/resources/doc/hod/a08resolutions.pdf

American Academy of Family Physicians

In 2007, an AAFP Commission declared that the association has a policy opposing any form of patient discrimination and stated its opposition to the exclusion of transgender health care: "RESOLVED, That the American Academy of Family Physicians endorse payment by third party payors to provide transsexual care benefits for transgender patients." http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/special/2007resolutions.Par.0001.File.tmp/2007NCSCSummActions-new-seal.pdf

World Professional Association of Transgender Health

The current Board of Directors of the WPATH herewith expresses its conviction that sex (gender) reassignment, properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or gender dysphoria. Sex reassignment plays an undisputed role in contributing toward favorable outcomes, and comprises Real Life Experience, legal name and

sex change on identity documents, as well as medically necessary hormone treatment, counseling, psychotherapy, and other medical procedures.

http://www.wpath.org/medical_necessity_statement.cfm

American Psychological Association

Whereas transgender people may be denied basic non-gender transition related health care (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; GLBT Health Access Project, 2000; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Riser et al., 2005; Rodriquez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

Whereas gender variant and transgender people may be denied appropriate gender transition related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender transition treatments (De Cuypere et al., 2005; Kuiper & Cohen-Kettenis, 1988; Lundstrom, et al., 1984; Newfield, et al., 2006; Pfafflin & Junge, 1998; Rehman et al., 1999; Ross & Need, 1989; Smith et al., 2005);

Therefore be it further resolved that APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals;

http://www.apa.org/about/policy/transgender.aspx

The "APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments." The APA Policy on Transgender, Gender Identity & Gender Expression Non-Discrimination can be accessed here:

http://www.apa.org/news/press/releases/2008/08/gender-variant.aspx

26. In summary, New York continues to uphold regulations regarding the treatment of transgender youth that are outdated and harmful. The most effective, humane and ethical care for transgender youth involves early and appropriate interventions that include puberty suppression, cross-sex hormones and gender confirmation surgeries. Delay or denial of such care will result in significant negative medical and mental health outcomes, profound depression, anxiety, and too often, suicide.

Dated: May 1, 2015

JOHANNA LYNN OLSON, M.D.

EXHIBIT A

CURRICULUM VITAE

A. Personal Information:

Name in Full	Johanna Lynn Olson, MD
Business Address	Children's Hospital Los Angeles Division of Adolescent Medicine 5000 Sunset Blvd. 4th Floor Los Angeles, CA 90027
Business Phone	(323) 653-2153 ext. 3128
Citizenship	USA
E-Mail Address	jolson@chla.usc.edu

B. Education:

High School	North Hollywood High School, 1987
College or University	University of California, San Diego, B.A., 1992
Graduate School	University of Health Sciences, The Chicago Medical School, North Chicago, Illinois, MS, 1993 University of Southern California, Keck School of Medicine, Los Angeles, California, MS – anticipated graduation Spring 2015
Medical School	Chicago Medical School, North Chicago, Illinois, MD, 1997
Internship	Children's Hospital Orange County (Pediatrics), Orange County, California July 1997 - June 1998
Residency	Children's Hospital Orange County (Pediatrics), Orange County, California July 1998 - June 2000
Fellowship	Children's Hospital Los Angeles (Adolescent Medicine), Los Angeles, California October 2000 – October 2003
Medical Licensure	Certificate A – 67352, California, 2000
Board Certification	American Board of Pediatrics - 2009 Adolescent Medicine - 2003

C. Professional Background:

Academic appointments

Medical Director – The Center for Transyouth Health and Development, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, California 2012 - present

Assistant Professor of Clinical Pediatrics, University of Southern California, Children's Hospital Los Angeles, Los Angeles, California
2006 - present

Adolescent Medicine Fellowship Director, Division of Adolescent Medicine, Children's Hospital Los Angeles, Los Angeles, California
2008 – 2012

Clinical appointments

University of California Los Angeles; Department of Pediatrics, Division of Adolescent Medicine, Los Angeles, California, 2003 - 2005

Pediatric Practice of Zimble/Reinstein, Encino, California, 2003 - 2006

Northeast Valley Health Corporation, San Fernando, California, 2004 - 2006

Kaiser Permanente, California Sunset, Los Angeles, California, 2002 - 2003

D. Society Memberships

Professional

Society for Pediatric Research – 2014 to present

World Professional Association for Transgender Health – 2010 to present

American Academy of Pediatrics – 2005 to present

Society for Adolescent Health and Medicine – 2006 to present

Los Angeles Pediatric Society – 2006 to 2011, Past President 2010

E. Service

Professional Organizations

National/International

Member, LGBT Special Interest Group, Society for Adolescent Health and Development, 2012 – present

Transyouth Family Allies, Executive Board Member, 2010-present

Local

Secretary, Executive Board Member, The Champion Fund/Children's Hospital Los Angeles, 2010 – present

Woodbury College IRB Committee, member, 2005-2008

Government Activities

Chair, Co-Founder, The Progressive Caucus of the California Democratic Party, California Democratic Party, California, 2004 – 2008

Journal Reviews

International Journal of Transgenderism
Journal of Adolescent Health
LGBT Health
Pediatrics

F. **Research Activities**

Major areas of Research Interest

Gender non-conforming children
Transgender adolescents and young adults
HIV adherence

Research in Progress

Treating Transgender Youth, an observational study undertaken in order to understand the physiologic and psychosocial impact of cross sex hormones in transgender youth.

Peri-pubertal Gender Non-Conforming Youth, an observational study designed to understand the impact of puberty suppression in gender non-conforming youth on bone density and psychosocial/mental health outcomes.

AMC-072, Protective Effect of Quadrivalent Vaccine in Young HIV-Positive Males who have Sex with Males.

ATN 078: A Pilot Study Using Cell Phone Interactions to Improve Medication Adherence in Adolescents Who Have Previously Failed Antiretroviral Therapy Due to Non-Adherence.

ATN 113, Project PrEPare- An Open Label Demonstration Project and Phase II Safety Study of Pre-Exposure Prophylaxis Use Among 15 to 17 Year Old Young Men Who Have Sex With Men (YMSM) in the United States.

ATN 109 A Randomized, Double-Blind, Placebo-Controlled Trial of the Safety and Effectiveness of Vitamin D3 50,000 IU Every 4 weeks to Increase Bone Mineral Density and Decrease Tenofovir-Induced Hyperparathyroidism in Youth with HIV Infection Being Treated with Tenofovir-Containing Combination Antiretroviral Therapy.

Research Grants

1. Treating transgender youth: the impact of a multidisciplinary care team approach, Clinical Research Career Development Award -Saban Research Center TSRI Program: Community Health Outcomes and Intervention Project, Principle Investigator, 2010-2012

2. The Impact of Hormone Blockers on the Physiologic and Psychosocial Development of Gender Non-Conforming Peri-Pubertal Youth, KL2 Mentored Career research Development Program of the Center for Education, Training and Career Development under the SC CTSI, Principle Investigator, 2012-2014

3. Adolescent Medicine Trials Network for HIV/AIDS Interventions, U01HD040463, NIH/NICHD, Co-Investigator, 2006 – 2016

   ATN 078: A Pilot Study Using Cell Phone Interactions to Improve Medication Adherence in Adolescents Who Have Previously Failed Antiretroviral Therapy Due to Non-Adherence.

   ATN 113, Project PrEPare- An Open Label Demonstration Project and Phase II Safety Study of Pre-Exposure Prophylaxis Use Among 15 to 17 Year Old Young Men Who Have Sex With Men (YMSM) in the United States.

   ATN 109 A Randomized, Double-Blind, Placebo-Controlled Trial of the Safety and Effectiveness of Vitamin D3 50,000 IU Every 4 weeks to Increase Bone Mineral Density and Decrease Tenofovir-Induced Hyperparathyroidism in Youth with HIV Infection Being Treated with Tenofovir-Containing Combination Antiretroviral Therapy.

G. Invited Lectures

International

Pubertal Suppression, The Los Angeles Experience, World Professional Association of Transgender Health Symposium, World Professional Association of Transgender Health, Bangkok, Thailand, February 2014

Social Transition in Childhood, World Professional Association of Transgender Health Symposium, World Professional Association of Transgender Health, World Professional Association of Transgender Health, Atlanta, Georgia, September 2011

Treating Transgender Youth; An Individualized Approach World Professional Association of Transgender Health Symposium, World Professional Association of Transgender Health, World Professional Association of Transgender Health, Atlanta, Georgia, September 2011

Caring for Gender Non-conforming Children and Adolescents in the New Millennium, Stigma and Resilience Among Vulnerable Youth Centre, Vancouver, Visiting Lecturer, March 2013

Other (last 5 years only)

Caring for Gender Non-conforming Children and Transgender Teens, Pediatric Grand Rounds, Harbor-UCLA Department of Pediatrics, Torrance, California, April 2015

Gender Non-conforming Children and Transgender Teens, Chico Trans Week, Stonewall Alliance Center of Chico, Chico, California, March 2015

Caring for Gender Non-conforming Children and Teens in the New Millennium, Healthcare Partners Pediatric Town Hall Meeting, Healthcare Partners CME, Glendale, California, March 2015

Caring for Gender Non-conforming Children and Teens in the New Millennium - A Multidisciplinary Team Approach; Seattle Children's Hospital Grand Rounds, Seattle Children's Hospital, Seattle, Washington, February 2015

Meeting the Needs of Transgender Adolescents; 1st Annual Southern California LGBT Health Symposium; USC/UCLA, Los Angeles, California, February 2015

Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; Eisenhower Medical Center Transgender Health Symposium, Palm Springs, January, 2015

Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Oakland, California, November 2014

Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Madera, California, October 2014

Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents; GetReal California's Initiative; "Integrating Sexual Orientation, Gender Identity, and Expression (SOGIE) into California's Child Welfare System," Santa Ana, California, October 2014

Transgender Youth; An Overview of Medical and Mental Health Needs of Gender Non-conforming Children and Transgender Adolescents, Models of Pride, Los Angeles LGBT Center's LifeWorks, Los Angeles, California, October 2014

Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Cultural Psychiatry Lecture Series, University of Iowa Carver College of Medicine, Iowa City, Iowa, September 2014

Caring for Gender Non-conforming Children and Teens in the New Millennium; A Multidisciplinary Team Approach, Children's Hospital Los Angeles Grand Rounds, Children's Hospital Los Angeles, Los Angeles, California, September 2014

Cross Sex Hormone Therapy for Transgender Teens, Southern Comfort Conference, Atlanta, Georgia, September 2014

Puberty Suppression, Southern Comfort Conference, Atlanta, Georgia, September 2014

Puberty Suppression in Gender Non-conforming Children, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2014

Cross sex Hormones, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2014

Transitioning Teens and the Adolescent Experience, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California, July 2014

Outside of the Gender Binary: Defining and Caring for Non-Binary Identified Youth , Gender Spectrum Family Conference, Gender Spectrum, Moraga, California, July 2014

Difficult Cases, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California, July 2014

Just a Boy, Just a Girl, Gender Spectrum Family Conference, Gender Spectrum, Moraga, California, July 2014

Medical Care of Transgender Adolescents, Cross sex Hormones, Gender Infinity Conference, Houston, Texas, June 2014

Cross-sex Hormones for Teenagers, How Young is Too Young?, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania, June 2014

Pediatric Update, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania, June 2014

Transgender Youth; Needs, Risks, Outcomes and the Role of the System , Including Permanency and Inclusion for Our Youth, Administrative Office of the Courts, Center for Families and Children, San Diego, California, May 2014

Medical Treatment of Gender Nonconforming and Transgender Youth, Chico Trans* Week, Stonewall Alliance & Chico California Association of Marriage and Family Therapists, Chico, California, April 2014

Transgender Youth 101, Stonewall LGBT Health Symposium, Los Angeles, California, March 2014

Mental and Physical Needs of Gender-Creative Children, Models of Pride, Los Angeles LGBT Center's LifeWorks, Los Angeles, October 2013

Mental and Physical Needs of Gender Creative Teens, Models of Pride, Los Angeles LGBT Center's LifeWorks, Los Angeles, October 2013

Medical Care of Transgender Youth, Gender Expansion Project, Missoula, Montana, October 2013

Puberty Delay in Transgender Youth, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2013

*The Future of Trans*youth Care*, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2013

Adolescent Medical and Mental Health Interventions for Gender Diverse Adolescents, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2013

Medical and Mental Health Support for Gender Diverse Children and Pre-Adolescents, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2013

Who Am I? Understanding and Supporting Multiple Facets of Gender Diverse Youth's Identities, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2013

Puberty Blockers for Transgender Youth, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2013

The Medical Needs of Transgender Youth, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2013

Pediatric Care for Transgender Youth, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania, June 2013

Toddlers to Teens: Clinical Work with Transgender Children Developing and Enriching Clinical Expertise, Philadelphia Trans Health Conference, Philadelphia, Pennsylvania, June 2013

Care of Transgender Children and Adolescents, 2013 National Transgender Health Summit, UCSF Center of Excellence in Transgender Health, Oakland, California, May 2013

Treating Transgender Youth: Basics of Cross-Sex Hormones, The Center for Strengthening Youth Prevention Paradigms Webinar, Children's Hospital Los Angeles, Los Angeles, California, October 2012

Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2012

What is the Future of TransYouth Health, Keynote, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2012

Gender Sensitive Care for Gender Non-Conforming Children and Youth, TransHealth Summit, Mountain Area Health Education Center, Ashland, North Carolina August 2012

Safety in School and Other Social Concerns, TransHealth Summit, Mountain Area Health Education Center, Ashland, North Carolina, August 2012

Toddlers to Teens: Comprehensive Health Care for the Transgender Child, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2012

Where Is The Science of Transgender Care? A Review of the Research, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2012

A New Terrain - Trajectories of Socially Supported Gender Nonconforming Children, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2012

Pediatric and Adolescent Gender Non-conformity, TransMedicine Education Initiative; Philadelphia Trans Health Conference, Philadelphia, Pennsylvania, June 2012

Approach to Care for the Transgender Adolescent, TransMedicine Education Initiative; Philadelphia Trans Health Conference, Philadelphia, Pennsylvania, June 2012

Suppression of Puberty in Peri-pubertal Transgender Youth, The Center For Strengthening Youth Prevention Paradigms Webinar, Children's Hospital Los Angeles, Los Angeles, California, June 2012

Transgender is a Pediatric Issue, North American Society for Pediatric and Adolescent Gynecology Annual Conference, North American Society for Pediatric and Adolescent Gynecology, Miami, Florida, April 2012

Gender Non-Conforming Children, Woodbury School of Psychology, Burbank, California, November 2011

Comprehensive Care for Transgender Teens, EDGY Conference, California Alliance of Child and Family Services, Los Angeles, California, October 2011

Gender Non-Conforming Children, UCLA Department of Psychology, Los Angeles, California, September 2011

Resolving the Tug Of War: Transitioning Teens, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2011

Toddlers to Teens: Health Care for Your Trans Child, Gender Odyssey Conference, Gender Odyssey, Seattle, Washington, August 2011

Transitioning Teens and the Adolescent Experience, Gender Spectrum Family Conference, Gender Spectrum, Berkeley, California, July 2011

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